

MEDICAL ASSISTANCE FOR FAMILIES and CHILDREN HANDBOOK

Commonwealth of Virginia
Department of Medical Assistance Services

www.dmas.virginia.gov



Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219-1857

Our mission is to provide a system of high quality comprehensive health services to qualifying Virginians and their families.

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General Information

Medical Assistance Programs in Virginia

Medical Assistance programs in Virginia are administered by the Department of Medical Assistance Services (DMAS). Eligibility for the programs is determined by the local Departments of Social Services (DSS).

Patient Protection and Affordable Care Act

Most individuals who do not receive Medicaid benefits must sign up for health insurance starting in 2014 or pay a penalty. If you currently receive Medicaid or FAMIS benefits and your situation does not change, you will probably still receive them. When your case is up for renewal, the local DSS will review it and let you know in writing of any changes. If you lose your Medicaid coverage a referral will automatically be sent to the Federal Health Insurance Marketplace. If you need help applying for medical assistance or insurance, go to the Cover Virginia website www.coverva.org or call Toll Free: 1-855-242-8282 • TDD: 1-888-221-1590. To apply directly for health insurance, subsidies or the Advance Premium Tax Credit (APTC), go to the Federal Health Insurance Marketplace at www.healthcare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325).

Medicaid

Medicaid (also sometimes called “FAMIS Plus”) is a medical assistance program that helps pay for medical care. To be eligible for medical assistance you must have limited income (and resources for certain groups), and you must be in one of the groups of individuals covered by Medicaid. See section on Covered Groups on page 8.

Medicaid is funded by the state and federal governments. Not everyone with high medical bills qualifies, but all individuals within a group are treated the same.

Medicaid provides either full coverage or limited coverage.

- Full coverage provides the full range of benefits including doctor, hospital and pharmacy services.
- Individuals and families who meet a spenddown have time-limited coverage; limited coverage is also provided to men and women who may be eligible for family planning services through Plan First.

FAMIS (Family Access to Medical Insurance Security) (similar medical programs for children, parents and pregnant women) and Medicaid for Aged, Blind and Disabled individuals have their own separate handbooks, also available from the DMAS website or your local DSS office.

How do I apply for Medical Assistance?

An application for Virginia medical assistance can be completed online at the CommonHelp website <https://commonhelp.virginia.gov/access/>. An application form can be printed from the Virginia DSS website www.dss.virginia.gov/form/. You can also contact the local DSS office in

the city or county where you live to pick up an application or have one mailed. The phone numbers for local DSS offices (sometimes called “human services” or “family services”) are listed in the blue pages of the phone book and online at <http://www.dss.virginia.gov/localagency/>. Applications can be filed at some hospitals. Applications for medical assistance are also accepted through the Cover Virginia Customer Care Center by phone at 1-855-242-8282 or through the internet at www.coverva.org.

An application must be signed by the person who needs assistance unless it is completed and signed by the applicant’s legal guardian, conservator, attorney-in-fact, or authorized representative. Electronic and telephonic signatures are acceptable. A parent, guardian, authorized adult representative, or caretaker relative with whom the child lives must sign the application for a child under the age of 18. Children under the age of 18 cannot apply for themselves, unless they are emancipated. However, if a child under the age of 18 has a child of his or her own, he or she as the parent can file an application for the child. A face-to-face interview is not required. You can designate an application counselor or navigator through CommonHelp to help you complete an application, but that person cannot sign the application for you.

A screening tool is available on the Virginia Department of Social Services (VDSS) website to help determine whether you or someone in your family may be eligible for medical assistance. Screening tools and more information can be found on the VDSS website at <https://commonhelp.virginia.gov> and on the www.coverva.org website. The final decision regarding eligibility will be made by an eligibility worker at your local DSS.

What Will I Be Asked?

Applicants for medical assistance are asked to provide their Social Security number, declare Virginia residency, and may be asked to provide documentation of United States citizenship and identity. If you are not a U.S. Citizen you must provide information and documents about your immigration status. Some immigrants can be eligible for full Medicaid coverage; others can be eligible for Medicaid payment only for emergency services. If you are pregnant, you will be asked how many babies you are expecting and the estimated date of delivery. Medical proof of pregnancy is no longer required.

Income that you receive must be listed on the application. Income includes earned income, such as wages and self-employment, as well as other income such as Social Security, retirement pensions, certain Veteran’s disability benefits, alimony, etc. Child support is generally not counted. Countable sources of income are added together and compared to the income limit to determine eligibility. You will also be asked questions about how you file your taxes to make sure we are counting the right income and including the right individuals in your household.

The income limits vary according to the covered group and the type of coverage. Total “gross income” is evaluated; deductions are allowed according to Medicaid policy, and the amount of income remaining is compared to the appropriate Medicaid limit. “Gross income” is the

amount before taxes or any deductions from the income are withheld. Your bills or debts are not used when we calculate whether your income is within the Medicaid limit.

Some individuals who meet all Medicaid eligibility requirements except for income may be placed on a “spenddown.” The spenddown amount is like a medical deductible – if medical expenses are higher than the spenddown amount, the individual may be eligible for Medicaid for a limited period of time. If a spenddown is needed, you will be asked to report your resources and provide verification of their value.

Who Makes the Decision, and How Long Does It Take?

Once a signed application is received, local DSS staff will determine whether you meet a Medicaid covered group (see section on Covered Groups) and if your resources (if required) and income are within required limits. The amount of income and resources you can have and still be eligible for Medicaid depends on how many family members are living together and the limits established for your covered group.

An eligibility decision will be made on your Medicaid application

(1) Within 45 calendar days **OR**

(2) Within 10 working days for pregnant women and participants in the Virginia Department of Health’s Every Woman’s Life Program (BCCPTA)

AFTER the signed application is received in the agency.

A written notice that your application has either been approved or denied will be mailed or given to you. If you disagree with the decision, you may file an appeal (see section on **When and How to File an Appeal**).

When Does Medicaid Start?

Medicaid coverage usually starts on the first day of the month in which you apply and are found to be eligible. Coverage can start as early as three months before the month in which you applied if you received a medical service during that time and met all eligibility requirements. Spenddown coverage begins once the spenddown is met and continues until the end of the spenddown period. Contact your local DSS office if you have questions about when your Medicaid coverage starts.

How Do I Keep My Coverage?

Once approved for Medicaid, coverage will continue for 12 months, as long as the eligibility requirements continue to be met. Medicaid coverage **must** be reviewed at least once every 12 months to determine continued eligibility for coverage. If this annual review is not completed, coverage may be canceled. In some cases your Medicaid coverage may be reviewed before the end of the 12 months. When your annual review is due, your local DSS will send you a notice. You may be asked to complete a form and supply proof of your current income. Some individuals will also have to provide current proof of their resources’ value.

If you are asked to complete a form or send in proof of income or resources, it is very important that you do so **immediately**. If you do not provide the information by the deadline given, Medicaid coverage may be canceled. If you need help completing the forms, contact your eligibility worker at your local DSS.

Sometimes your eligibility may be reviewed for another 12 months using information available to your local DSS eligibility worker. If the local DSS is able to renew Medicaid coverage with information they already have, you will receive a notice telling you the coverage has been reviewed and the date of your next annual renewal. You can also renew your coverage on a computer by visiting the CommonHelp website.

REMEMBER - You must report any change in circumstances (such as a change of address or locality, income, or health insurance coverage) **within 10 calendar days of the change on the CommonHelp website or by contacting your local DSS worker.** If the reported change affects your eligibility for medical assistance, your case will be reviewed and you will be notified of the outcome. If you apply or are reviewed for another program provided by social services [such as SNAP (Food Stamps) or TANF] the eligibility worker will renew your medical assistance at the same time if possible and extend your coverage for another 12 months from that date.

If you continue to receive coverage because you failed to report changes on time, your case may be referred to the DMAS Recipient Audit Unit (RAU) for an evaluation of possible Medicaid fraud. That evaluation could result in the RAU requesting repayment for Medicaid services or for premiums paid to Managed Care Organizations (if any) to cover your medical services.

IT IS VERY IMPORTANT to tell your local DSS right away if you move or change your address. If DSS does not have a correct address, you will not receive a notice when it is time to renew medical assistance coverage and **your coverage may be canceled**. If you have a change in your address at any time, contact your local DSS right away to protect your coverage.

COVERED GROUPS

Federal and state laws describe the groups of individuals who may be eligible for Medicaid, referred to as “Medicaid covered groups.” Individuals who meet one of the covered groups may be eligible for Medicaid if their income and resources are within the required limits of the covered group. Services may also differ depending on the covered group.

The **Medicaid covered groups** for Families and Children are:

- **Pregnant women** (single or married) whose family income is at or below 143% of the Federal Poverty Income Guidelines*
- **Children:**
 - from birth to age 19 whose family income is at or below 143% of the Federal Poverty Income Guidelines*
 - Children under age 21 who are in foster care or subsidized adoptions/Infants born to Medicaid-eligible women
- Adults under age 26 who were in Virginia Foster Care and receiving Medicaid when they turned 18
- Parents or relative caretakers with low income group called Low Income Families with Dependent Children (**LIFC**) – see income limits on website listed below
- **Medically Needy** individuals who meet Medicaid covered group requirements but have income over the Medically Needy limit
- Individuals screened by the Virginia Department of Health’s Every Woman’s Life Program (**BCCPTA**) who have been diagnosed and need treatment for breast or cervical cancer

Note: Children from birth to age 19 whose family income is above 143% of the Federal Poverty Income Guidelines* may qualify for FAMIS

*The Federal Poverty Income Guidelines are available on the DSS website at:
http://www.dss.virginia.gov/benefit/medical_assistance/index.cgi

Plan First – Virginia’s Family Planning Services Program

Men and women who meet the income requirements but do not meet a full-benefit Medicaid covered group may be eligible for the limited Medicaid benefit Plan First. Plan First covers:

- Annual family planning exams for men and women
- Pap tests
- Sexually transmitted infections (STI) testing
- Family planning education and counseling
- Sterilization procedures
- Transportation to a family planning service
- Most Food and Drug Administration (FDA) approved contraceptives (prescription and over-the-counter)

Individuals applying for full-benefit coverage or losing full-benefit coverage because they no longer meet a covered group for full benefits may have eligibility for Plan First evaluated. **If applicants do not want to be considered for Plan First enrollment, they must tell the eligibility worker.**

All Plan First participants will be referred to the Federal Health Insurance Marketplace to be evaluated for APTC or cost sharing reductions.

Emergency Services for Non-Citizens

Special rules apply to non-citizens. If a person meets one of the covered groups listed above but is not a U.S. citizen, his/her immigration status and date of entry into the United States affect eligibility for Medicaid coverage. If the immigration status affects Medicaid coverage, he/she may be eligible for Medicaid to pay for services limited to emergency medical treatment if all other Medicaid eligibility requirements are met.

MEDICAID AND OTHER INSURANCE

If you already have health insurance you can still be covered by Medicaid. The other insurance plan is always billed first. Having other health insurance does not change the Medicaid co-payment amount (if any) that you pay to providers as a Medicaid enrollee. If you drop private health insurance coverage or enroll in a private health insurance plan, tell your eligibility worker. If you don't, medical bill payments could be delayed.

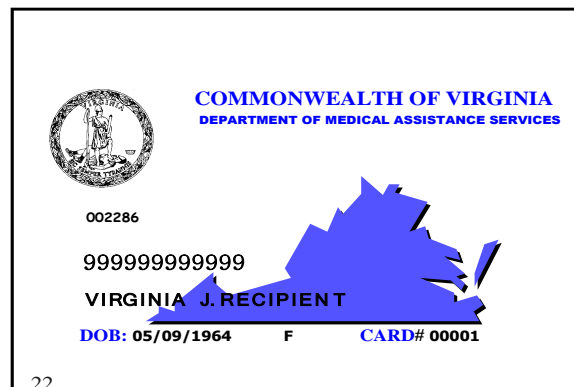
Sometimes Medicaid pays claims for covered services and it is later found that another payment source was available. In this situation Medicaid will try to recover the money from the other source, whether from commercial insurance, Medicare, Worker's Compensation, or liability insurance (if the claim is for an accident). The agreement to "Assign Rights to Medical Support and Third-Party Payments" is included in the medical assistance application. If you are paid by an insurance company after Medicaid has already paid the same bill, you must send that money to DMAS.

Health Insurance Premium Payment Programs (HIPP)

Medicaid may help with the cost of private health insurance premiums when certain criteria are met. The HIPP Programs only reimburse for employer sponsored group health plans; they do not reimburse premiums for individual policies. You local DSS can provide information regarding this program, or call the DMAS Health Insurance Premium Payment Unit at 1-800-432-5924 or send an email to: hippcustomerservice@dmass.virginia.gov.

VIRGINIA MEDICAID CARD

When you are found eligible you will be mailed a blue and white plastic medical assistance card (Virginia Medicaid card) on which your name and identification number are printed. **It is your responsibility to show your Virginia Medicaid Card to providers at the time you go for services and to be sure the provider accepts payment from Virginia Medicaid.** If you have a Virginia Medicaid card because you were eligible at an earlier time, **keep it.** That card will be valid again if and when your coverage is reinstated.



Using Your Medical Card

Each person in your family who is eligible for Medicaid will receive his or her own card (unless only eligible for Medicaid payment of Medicare premiums). You will **not** be mailed a new card if your benefits change. You can request a replacement card from the local DSS if your card is lost, stolen or destroyed.

Show your card(s) **each time you get a medical service** so that your medical provider can verify your current eligibility status. If you are enrolled in a Managed Care Organization (MCO), you will get a separate card from that organization. **You need to show both the MCO and the Virginia Medicaid cards when you receive medical care.** If you do not show your card(s), you may be treated as a private-pay patient and receive a bill from the medical provider.

It is your responsibility to show your medical identification card(s) to providers at the time you go for service and to be sure the provider accepts payment from Virginia Medicaid or from your assigned MCO, if you have one. Report the loss or theft of your Virginia Medicaid card to the local DSS right away. The loss or theft of your MCO card should be reported to your MCO.

USING YOUR MEDICAID BENEFITS

Medicaid provides medical services both by direct payments to providers and by paying premiums for participants to Managed Care organizations.

“Fee for Service” Medicaid Coverage

Providers who are enrolled with DMAS offer care directly to some Medicaid participants. If you do not have an assigned doctor or MCO, you can choose any provider for medical services as long as the provider accepts Virginia Medicaid payments. If you receive services from providers who are not enrolled in Virginia Medicaid, **you will have to pay the bill. Medicaid will not pay you back for the medical bills that you have paid.** Try to use one doctor and one pharmacy for most of your care, and continue with that doctor unless you are referred to a specialist. If you need help finding a provider who accepts Medicaid, check the DMAS Provider Search Engine <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/SearchForProviders>. If a provider type you are looking for is not listed, contact our Helpline at 804-786-6145.

Managed Care

Most Virginia Medicaid members are required to receive their medical care through Managed Care Organizations (MCOs). Program eligibility is determined by where you live. If you meet the criteria to be assigned to an MCO you will receive a letter from DMAS requiring you to choose a MCO for your health care. You will receive information about the programs such as an MCO Comparison Chart and a brochure. **If you do not make a choice, DMAS will assign you to an MCO.**

Managed Care Organizations (MCOs)

An MCO is a health service organization that coordinates health care services through a network of providers including primary care providers (PCPs), specialists, hospitals, clinics, medical supply companies, transportation service providers, drug stores, and other medical service providers. Once you select an MCO, a packet of information will be mailed directly to you. You also will receive an MCO identification card to use with your medical ID card. **Please keep both cards with you and present both cards each time medical care is received.** The MCO will require you to choose a PCP in its network who will manage all of your health care needs. You are not required to enroll all members of your family in the same MCO or with the same PCP.

You will be required to follow managed care program rules. These rules are described in the MCO member handbook, which is included in the information packet that your MCO will send to you. If you do not follow the managed care program rules you may have to pay the full bill yourself. Refer to your MCO member handbook for more details.

Open Enrollment

There is an annual open enrollment period for the MCO programs. This open enrollment period allows you to change your MCO. If you want to know when your open enrollment period takes place or have other questions regarding your managed care enrollment, call the DMAS Managed Care Helpline at 1-800-643-2273. See the DMAS website for more information: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx

Client Medical Management (CMM)

Some individuals need special help with their doctor and pharmacy use. If you are identified for enrollment in Client Medical Management (CMM), you will receive a letter from the DMAS Recipient Monitoring Unit (RMU). You will have the chance to choose your PCP and pharmacy within 30 days of receiving the enrollment notice. **If you do not tell Medicaid your choices, DMAS will choose providers for you.** Once you are assigned to one doctor and/or pharmacy, you must get your care only from them unless they refer you to other providers. Your PCP must give you written permission (a referral form) when you need to see a specialist. You may only use another pharmacy in an emergency as explained by CMM rules. Your plastic card contains information like a credit card, which tells the provider the names of your CMM providers. Each CMM member is assigned a RMU case manager to answer questions about the program and assist you in following the program rules.

Each Managed Care Organization has a program similar to the CCM. If you are identified for enrollment in one of these programs you will be notified by your MCO.

MEDICAL CARE THROUGH MEDICAID

Most medical care, both inpatient and outpatient, is covered by Medicaid. There are certain limits and rules that apply. For example, some medical procedures must be performed as outpatient surgery unless there is a medical need for hospital admission. Care in an institution for the treatment of mental diseases is not covered for individuals between the ages of 21-64. There are limits to the number of visits approved for home health, psychiatric services, and other professional services. Some services require prior authorization.

Behavioral Health Services

As of December 1, 2013, Magellan Behavioral Health, Inc. (Magellan of Virginia) manages behavioral health services. Magellan manages all Medicaid covered mental health and substance abuse treatment services for fee-for-service enrolled members, and coordinates benefits with the MCOs. Services Magellan manages include:

- Intensive In-Home Services for Children and Adolescents (IIH)
- Therapeutic Day Treatment for Children and Adolescents (TDT)
- Group Home Services for Children and Adolescents
- Residential Treatment

- Day Treatment/Partial Hospitalization
- Psychosocial Rehabilitation
- Intensive Community Treatment (ICT)
- Mental Health Support Services (MHSS)
- Crisis Intervention and Stabilization
- Case Management
- Substance abuse programs
- Outpatient Therapy (if you are not enrolled in a MCO)
- Traditional mental health needs, such as medications for mental health or substance abuse needs, are managed by the Managed Care Organization for MCO members

For more information about behavioral health services call Magellan at 1-800-424-4046.

Dental Care - Smiles for Children

The Smiles for Children program provides coverage for diagnostic, preventive, restorative/surgical procedures and orthodontia services for Medicaid children. The program also provides coverage for limited medically necessary oral surgery services for adults (age 21 and older). DentaQuest is the single dental benefits administrator that coordinates the delivery of all Smiles for Children dental services. If you need help finding a dentist or making a dental appointment, please call 1-888-912-3456 to speak with a Smiles for Children representative.

Inpatient Hospital Admissions

Your doctor must call for pre-authorization before you are admitted to the hospital, or within 24 hours after an emergency admission.

Medical Professional Visits

Appointments for psychiatric, nursing, physical therapy, occupational therapy and speech therapy visits must be pre-approved.

Pharmacy

Your doctor may have to get pre-authorization in order for a pharmacy to fill some prescriptions. Within a family of drugs, there may be one or a few select drugs that Medicaid or the Managed Care Organization would like your doctor to use to treat your condition because they are safe, effective, or less costly. This is called a Preferred Drug List (PDL) or formulary. You can still receive medication to effectively treat your medical condition. Prior approval is required to fill the prescription if the drug is not on the PDL or formulary. A doctor may also prescribe or order some over-the-counter drugs equivalent to certain prescription drugs if it is cost-effective to do so. When available, generic drugs are dispensed unless the doctor specifies that a particular brand name is medically necessary. This is true whether you get services directly through Medicaid (administered by Magellan Health Services) or through an MCO. If you have questions about the PDL, call Magellan at 1-800-932-6648, your MCO, or talk to your doctor.

School Health Services

If your child is eligible for Medicaid or FAMIS and he or she receives health-related services specified in an Individualized Education Program (IEP), federal funds available to DMAS can help the public school division pay for these health-related services. Health-related services can include, but are not limited to:

- physical, occupational or speech therapy
- audiology
- nursing
- psychological and mental health services
- personal care services
- health screening associated with Early Periodic Screening Diagnosis and Treatment (EPSDT)
- Specialized transportation on days your child is receiving a health-related service may also be covered

Your child's health coverage for services outside the school system will not be impacted by the school billing Medicaid or FAMIS.

Transportation

Transportation services are provided when necessary to help individuals access Medicaid covered services. Full-benefit Medicaid covers two types of transportation:

- **Emergency** – Medicaid pays for **911** emergency transportation to receive medical treatment.
- **Non-Emergency** – Non-emergency medical transportation is provided through a transportation broker or through your MCO.

Transportation may be provided if you have no other means of transportation and need to go to a physician or a health care facility for a Medicaid-covered service. In case of a life-threatening emergency, call 911. For non-emergency medical appointments, call the reservation line at 1-866-386-8331 at least five business days (5 days) prior to the scheduled appointment. (Verifiable "URGENT" trips, like hospital discharges or a sudden illness, may be accepted with less than five days.) Please have your Medicaid ID number, appointment address and telephone number available when you call. Members in an MCO should call the transportation number listed in the MCO member handbook to arrange for non-emergency trips.

Additional Non-Emergency Medicaid Transportation information can be found at <http://transportation.dmas.virginia.gov>.

Remember: Trips must be for a Medicaid covered service and medically necessary. Some examples are doctor's appointments, counseling, dialysis and adolescent dental appointments. The transportation broker may verify your Medicaid covered service with the Medicaid provider.

Out-of-State Medical Coverage

Virginia Medicaid will cover emergency medical services you receive while temporarily outside of Virginia if the provider of care agrees to participate in Virginia's Medicaid Program and to bill Medicaid. **No payments are made directly to members for services received out of state.** Rules for out-of-state care may be different if your coverage is through an MCO. If you are enrolled in an MCO, contact MCO staff for procedures regarding out-of-state treatment.

If you receive emergency medical services out of state from a provider not enrolled in Virginia Medicaid, ask the provider to contact the DMAS Provider Enrollment Unit:

Virginia Medicaid Provider Enrollment Services
P.O. Box 26803
Richmond, Virginia 23261
Phone: 1-888-829-5373 or 804-270-5105

Virginia Medicaid does not cover medical care received outside of the United States.

CO-PAYMENTS

Some Medicaid members must pay a small amount for certain services. This is called a co-payment.

Children younger than age 21 do not pay a co-payment for services covered by Medicaid.

Medicaid does not charge a co-payment for the following services

- Emergency services (including dialysis treatments)
- Pregnancy-related services
- Family-planning services
- Emergency room services

You are responsible for paying the co-payment, if any. However, a medical provider **cannot** refuse to treat you or provide medical care if you are not able to pay the co-payment.

As an additional benefit of participation in an MCO, members are not charged co-payments for services.

BENEFITS THROUGH MEDICAID

A description of each benefit follows this list. If your coverage is provided by an MCO, contact the MCO for coverage criteria.

- BabyCare (including Prenatal and maternal care)
- Clinic Services
- Community-Based Residential Services for Children and Adolescents under 21
- Community Mental Health and Intellectual Disability Services
- Dental Care Services
- Durable Medical Equipment and Supplies (**DME**)
- Early and Periodic Screening, Diagnosis, and Treatment (**EPSDT**) – most frequently provided specialized services are:
 - Residential Behavioral Treatment
 - Assistive Technology
 - Behavioral Therapy
 - Hearing Aids
 - Medical Formula and Medical Nutritional Supplements
 - Personal Care
 - Private Duty/Specialized Nursing
 - Specialized Services to Address Complex Medical Needs
 - Substance Abuse Treatment
- Early Intervention
- Eye Examinations
- Eyeglasses
- Family Planning Services
- Glucose Test Strips
- Home Health Services
- Hospice
- Hospital Care – Inpatient/Outpatient
- Hospital Emergency Room
- Lead Testing
- Long-Term Care
- Money Follows the Person (**MFP**) Program
- Nursing Facility
- Organ Transplants
- Personal Care
- Physician's Services
- Podiatry Services (foot care)
- Prenatal and Maternity Services
- Prescription Drugs when ordered by a Physician
- Prosthetic Devices

- Psychiatric or Psychological Services
- Renal (Kidney) Dialysis Clinic Visits
- Rehabilitation Services
- Residential Treatment Services (Level C)
- Therapeutic Behavioral Services (Level B)
- Tobacco cessation services and nicotine replacement therapy for pregnant women
- Transportation Services for Medical Treatment
- Treatment Foster Care – Case Management (TFC-CM)

BabyCare – Case Management for high-risk pregnant women and infants up to age two enrolled in Medicaid, FAMIS, and FAMIS MOMS. Expanded prenatal services provided through BabyCare are available to help women have a positive pregnancy outcome. These services are

- Prenatal education for a variety of topics including tobacco cessation, preparation for childbirth, and parenting
- Nutritional assessment and counseling
- Homemaker services to members for whom the physician has ordered complete bed rest
- Substance Abuse Treatment Services

Clinic Services - Facilities (public and private) for the diagnosis and treatment of persons receiving outpatient care.

Community-Based Residential Services for Children and Adolescents under 21 - Level A – Community Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. The residential service will provide structure of daily activities, psycho-education, therapeutic supervision, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service.

Community Mental Health and Intellectual Disability Services – Services provided in the individual's home or community that provide diagnosis, treatment, or care of persons with mental illnesses, substance abuse or intellectual disability. These services are provided primarily by Community Services Boards and private providers.

Dental Care Services – Individuals under age 21 are eligible for comprehensive services including diagnostic, preventative, restorative/surgical procedures and orthodontics. Dentures, braces, and permanent crowns are covered for those under 21 when prescribed by a dentist and pre-authorized by DMAS. Adult coverage is limited to medically necessary oral surgery and associated diagnostic services.

Durable Medical Equipment and Supplies (DME) – Medically necessary medical equipment and supplies may be covered when they are necessary to carry out a treatment prescribed by a physician. For example:

- Ostomy supplies
- Oxygen and respiratory equipment and supplies
- Home dialysis equipment and supplies

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – A program of preventive health care and well child examinations with appropriate tests and immunizations for children and teens from birth up to age 21 to keep children healthy. Medically necessary services, which are required to correct or improve defects and physical or mental illnesses that are discovered during a screening examination, may be covered as a part of the EPSDT program even if they are not covered under the State's Medical benefit plan.

Early Intervention – Case management and other services designed to meet the developmental needs of infants or toddlers with a developmental delay up to age three. This program also helps meet the needs of the family related to enhancing the child's development.

Eye Examinations – Limited to once every two years.

Eyeglasses – Covered only for members younger than 21 years of age.

Family Planning Services/Birth Control – Services that delay or prevent pregnancy including diagnosis, treatment, drugs, supplies, devices and certain elective sterilization procedures (for men and women). Coverage of such services does not include services to treat infertility or services to promote fertility.

Glucose Test Strips – Blood glucose self-monitoring test strips are covered when medically necessary.

Home Health Services – Visits by a nurse, physical therapist, occupational therapist, or speech and language therapist require prior approval. The visits of a home health aide are limited to 32 visits annually.

Hospital Care -

- **Inpatient:** Admission to a hospital for bed occupancy to receive hospital services. Approved days are covered.
- **Outpatient:** Receiving medical services but not admitted to a hospital.

Hospital Emergency Room – Visits are covered for emergency treatment of serious life- or health-threatening medical problems

Lead Testing – Lead testing is required for every Medicaid-eligible child as part of the 12- and 24-month EPSDT screenings. It is also administered to any child between the ages of 36 and 72 months old who has not been previously screened.

Long-Term Care – This may include care in an institutional setting such as a Nursing Facility or Intermediate Care Facility for Individuals with Intellectual Disability or in the community through a Home and Community-Based Care Waiver.

Money Follows the Person (MFP) Program - This eight year project, funded by federal and state sources, provides individuals of all ages and all disabilities who live in institutions in the Commonwealth of Virginia [such as nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and long-stay hospitals, institute for mental disorders (IMD), psychiatric residential treatment facility (PRTF)] options to transition to a home and community setting. For additional information see www.olmsteadva.com/mfp/.

Nursing Facility – A licensed and certified facility which provides services to individuals who do not require the degree of care and treatment provided in a hospital setting.

Organ Transplants – Kidney, liver, heart, lung, cornea, high-dose chemotherapy, and bone marrow/stem cell transplantation are covered. All transplants except corneas require pre-authorization.

Personal Care – Support services to assist with activities of daily living (bathing, dressing, toileting, transferring, eating, bowel and bladder continence necessary to maintain health and safety), monitoring of self-administered medications, and the monitoring of health status and physical condition. These services are provided for individuals of any age enrolled in a home or community based waiver who meet established medical necessity criteria, and for members under the age of 21 under EPSDT. Services do not take the place of informal support systems.

Physician's Services – Medical services provided by general practitioners, specialists, and osteopaths.

Podiatry Services (foot care) – Routine and preventive foot care is not covered by Medicaid. Payment for the trimming of the nails for a medical condition such as diabetes is limited to once every 2 months.

Prescription Drugs when ordered by a Physician – Medicaid has a preferred drug list (PDL), but drugs not on the list can be covered if pre-authorized. Prescriptions are filled with no more than a 34-day supply at a time. When available, generic drugs are dispensed unless the doctor specifies that a particular brand name is medically necessary. Some over-the-counter drugs can be covered if ordered by a doctor instead of a prescription drug. **Medicaid members who have Medicare coverage must receive their prescription drug coverage under Medicare Part D.** For information about coverage under Medicare Part D, call 1-800-MEDICARE (1-800-633-4227).

Prosthetic Devices – Limited to artificial arms, legs, and the items necessary for attaching the prostheses; must be preauthorized.

Psychiatric or Psychological Services – Medicaid covers up to 26 out-patient mental health or substance abuse service hours without preauthorization. Additional treatment must be pre-authorized. Contact your Managed Care Organization for their criteria.

Renal (Kidney) Dialysis Clinic Visits – Outpatient visits for dialysis treatment of end-stage renal disease are a covered service. The visit may have two components, the outpatient facility and the physician evaluation and management fees.

Rehabilitation Services – Outpatient services for physical therapy, occupational therapy, and speech-language pathology.

Residential Treatment Services (Level C)- Freestanding Hospital and Residential Treatment Facility Services for Children and Adolescents under Age 21 whose need for psychiatric services to treat severe mental, emotional and behavioral disorders is identified through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Services must be medically necessary and preauthorization is required.

Therapeutic Behavioral Services (Level B) – Community-Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. These services will provide structure for daily activities, psycho-education, therapeutic supervision, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs or facilities with 16 or fewer beds are eligible to provide this service.

Transportation Services for Medicaid Covered Services:

Emergency – Full Medicaid covers 911 emergency transportation to receive medical treatment.

Non-Emergency – Non-emergency medical transportation is arranged through a transportation broker or through your MCO. Not all Medicaid members receive transportation services. If you are eligible for transportation benefits and do not have a car or a family member who can transport you to a Medicaid-covered service appointment and you are not enrolled in an MCO, call for assistance toll-free at 1-866-386-8331.

Additional Non-Emergency Transportation information can be found at [/transportation.dmas.virginia.gov](http://transportation.dmas.virginia.gov)

Treatment Foster Care – Case Management – Case Management Services for children who are in therapeutic foster care.

WHAT IS NOT COVERED BY MEDICAID?

Some services below may be covered for members under age 21 under EPSDT*

- Abortions, unless the pregnancy is life-threatening
- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Alcohol and drug abuse therapy*
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Broken appointments
- Certain drugs not proven effective and those offered by non-participating manufacturers (enrolled doctors, drugstores, and health departments have lists of these drugs)
- Certain experimental surgical and diagnostic procedures
- Chiropractic services (except as provided through EPSDT*)
- Cosmetic treatment or surgery
- Daycare, including sitter services for the elderly (except in some home- and community-based service waivers)
- Dentures for members age 21 and over
- Doctor services during non-covered hospital days
- Drugs prescribed to treat hair loss or to bleach skin
- Eyeglasses or their repair for members age 21 or older
- Hospital charges for days of care not authorized for coverage including Friday or Saturday hospital admission for non-emergency reasons or admission for more than one day prior to surgery
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk)
- Inpatient hospital care in an institution for the treatment of mental disease for members under age 65 (unless they are under age 22 and receiving inpatient psychiatric services)
- Medical care received from providers who are not enrolled in or will not accept Virginia Medicaid
- Personal care services (except in some home and community-based service waivers or under EPSDT*)
- Private duty nursing (except in some home and community-based service waivers or under EPSDT*)
- Psychological testing done for school purposes, educational diagnosis, school, or institution admission and/or placement or upon court order (Psychological tests performed by local education agencies that are in child's Individual Education Plan [IEP] are covered under school-based health services)
- Remedial education
- Routine dental care if you are age 21 or older

- Routine school physicals or sports physicals
- Sterilization of members younger than age 21
- Telephone consultation
- Weight loss clinic programs

This list does not include every service that is not paid for by Medicaid. If you receive a service not covered by Medicaid or you receive more services than the Medicaid limit for that service, you will have to pay those bills.

SERVICES FOR CHILDREN/EPSDT

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a comprehensive and preventive child health program for members in Medicaid up to age 21 that detects and treats health care problems through:

- ✓ Regular medical, dental, vision, and hearing check-ups
- ✓ Diagnosis of problems
- ✓ Treatment of dental, eye, hearing, and other medical problems discovered during check-ups

EPSDT IS FREE:

- ✓ Medicaid will pay for the EPSDT check-ups.
- ✓ Medicaid will pay for the treatment of dental, vision, hearing, and other medical problems, found during a check-up.
- ✓ If eligible for transportation benefit, Medicaid will provide transportation to your child's appointment. Contact your Managed Care Organization, or if you do not have a Managed Care Organization call toll-free: 1-866-386-8331.

EPSDT exams (check-ups) are done by your child's doctor and must include:

- ✓ A complete history of your child's health, nutrition, and development
- ✓ A head-to-toe physical exam
- ✓ Health education
- ✓ A growth and development check
- ✓ Lab tests
- ✓ All children must be tested for lead exposure at 12 and 24 months of age or before the age of 6 if not previously tested
- ✓ Shots/immunizations, as needed
- ✓ Eye check-up
- ✓ Hearing check-up
- ✓ Referral to a dentist by the age of three

Dental check-ups with a dentist should be done every 6 months. For a referral to a dentist contact Smiles for Children at 1-888-912-3456.

You should take your child to the doctor for check-ups early and on a regular basis. Getting regular EPSDT Check-Ups even when your child is not sick is the best way to make sure your child stays healthy!

Use the chart below to find out when your child should receive regular check-ups:

Babies need check-ups at:	Toddlers & Children need check-ups at:	Older Children need check-ups at:	Teenagers need check-ups at:
3-5 days 1 month 2 months 4 months 6 months 9 months 12 months	15 months 18 months 2 years 30 months 3 years 4 years	5 years 6 years 7 years 8 years 9 years 10 years 11 years	12 years 13 years 14 years 15 years 16 years 17 years 18 years 19 years 20 years

Ask your doctor for more information about immunizations

If a treatment or service is needed to correct or improve a problem that is found during an EPSDT check-up, or prevent a problem from getting worse, talk with your child's doctor. There are services covered through EPSDT that are not normally covered by Medicaid. Your child may be referred for medically necessary specialty care or other health services if the PCP or screening health care provider is not able to provide the treatment or service.

LONG-TERM CARE (LTC) SERVICES

Medicaid pays for LTC services in some institutional settings, such as nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disability, and for individuals in their communities through Home and Community-Based Care Waivers. To qualify for LTC services, an individual must meet certain level-of-care requirements. These requirements may include assistance with activities of daily living and a medical nursing need. In order to receive waiver services there is a Federal requirement that the individual be at risk of institutionalization within 30 days if waiver services are not provided. There are eligibility rules and requirements (such as preadmission screening, asset transfer evaluation and patient pay) which only apply to individuals who need Medicaid coverage for long-term care services. When a child is medically screened, has been institutionalized for 30 days and requires LTC services, income and resources of his or her parent (s) are not included in the financial determination. Contact your local DSS for details if Medicaid long-term care services are needed.

Screening for Long-Term Care Services

A pre-admission screening is required to determine whether an individual meets the level-of-care criteria for long-term care services. Screening is not required if the person is entering the facility directly from another state. Screenings for institutional and community-based long term care are completed by the following teams:

- Local teams composed of health and social service agencies
- Staff of acute care hospitals
- Community Services Board Staff Intellectual Disability waiver only)
- Child Development Clinics Staff (Developmental Disabilities waiver only)

Home and Community-Based Waivers

Virginia provides a variety of services (such as personal care) under Home and Community-based waivers to specifically targeted individuals. Each waiver provides specialized services to help eligible individuals remain in their communities. These individuals receive acute and primary medical services from a MCO and waiver services (and the related transportation) through the fee-for-service program. The waivers that pertain to children are:

- **Elderly or Disabled with Consumer Direction (EDCD) Waiver** - provides supports in the community for individuals who are elderly or have a disability. Individuals may choose to receive agency-directed services, consumer-directed services or a combination of the two as long as it is medically appropriate and duplicate services are not provided
- **Individual and Family Developmental Disabilities (DD) Support Waiver** - provides supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability. The DD waiver serves individuals 6 years of age and older who have a

related condition and do not have a diagnosis of intellectual disability, and who (1) meet the ICF level of care criteria, (2) are determined to be at imminent risk of ICF/IID placement, and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being placed in an ICF/IID.

- **Intellectual Disability (ID) Waiver** - provides supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have an intellectual disability.
- **Technology Assisted (Tech) Waiver** - provides supports in the community for individuals who are dependent upon technological support and require substantial, ongoing nursing care.
- **Day Support (DS) Waiver for Individuals with Intellectual Disability (IID)** – provides home and community-based services to individuals with intellectual disability who have been determined to require the level of care provided in an ICF/ IID and are on the waiting list for the ID Waiver.

YOUR RIGHTS AND RESPONSIBILITIES

You have the right to ...

- File an application for assistance.
- Receive written information about specific eligibility policies.
- Have a decision made promptly.
- Receive a written notice of the decision.
- Have your personal and health information kept private.
- Have advance notice of actions that end or reduce your coverage
- Appeal any action, such as:
 - any decision denying, terminating or reducing Medicaid eligibility;
 - any unreasonable period of time taken to decide if you are eligible;
 - any decision denying, terminating or reducing Medicaid-covered medical services.

You have the responsibility to...

- Complete the application and renewal forms fully and accurately.
- Supply requested information, or to tell your eligibility worker about any problems you are having getting the necessary information.
- Inform your eligibility worker of any other medical insurance that may cover some of your bills.
- **Immediately report** changes in your circumstances to your worker such as:
 - Change of address, birth of a child, death of a family member, marriage, new employment, adding or dropping other health insurance or any change in household arrangements.
 - The early termination or loss of pregnancy.
 - Changes in your financial condition (which includes both earned and unearned income such as Social Security, SSI, going to work, changes in employment, transfers of assets or inheriting). Any medical insurance that may cover some of your bills.
 - Filing a personal injury claim due to an accident.
- Keep scheduled appointments.
- Show your medical provider your Medicaid and other medical insurance card(s) when you go for care.

FRAUD AND OTHER RECOVERIES

Medicaid fraud means deliberately withholding or hiding information or giving false information to get Medicaid benefits. Medicaid fraud also occurs when a provider bills Medicaid for services that were not delivered to a Medicaid member, or if a member allows another person to use his/her Medicaid number to get medical care for someone who has not been determined eligible for Medicaid benefits.

Anyone convicted of Medicaid fraud in a criminal court must repay the Medicaid program for all losses (paid claims and managed care premiums) and cannot receive Medicaid benefits for one year after conviction. In addition, the sentence could include a fine up to \$25,000 and/or up to 20 years in prison. You may also have to repay the Medicaid program for any claims and managed care premiums paid during periods you were not eligible for Medicaid due to acts not considered criminal. Fraud and abuse should be reported to your local Department of Social Services or to the DMAS Recipient Audit Unit at (804) 786-0156. Additional numbers for reporting suspected fraud and abuse are (804) 786-1066 (local) and toll free 1-866-486-1971. Fraud and abuse can also be reported by e-mail to recipientfraud@dmass.virginia.gov.

Medicaid can also recover payments made for services received by, or managed care premiums paid on behalf of, ineligible members who did not intend to commit fraud. **This also includes recovery for medical services received during an appeal process when the agency's action is upheld.** There is no time limit for Medicaid recoveries.

If you are enrolled in a Medicaid MCO, premiums are paid by Medicaid to the MCO every month for your coverage, even if you do not use any medical services that month. These premiums are considered losses to the program and can be recovered if you are determined ineligible for any prior period. If you are found to be ineligible for prior months of coverage due to your failure to report truthful information or changes in your circumstances to your caseworker, you may be liable to repay these monthly premiums.

Third Party Liability and Personal Injury Claims

If you have been injured in any type of accident and have a personal injury claim, you must inform your eligibility worker so that Medicaid may recover payment from the person responsible for the accident. The agency will need information such as the date of the accident/injury, type of accident and the name of the attorney or insurance company, if any.

WHEN AND HOW TO FILE AN APPEAL

You have the right to request an appeal of any adverse action related to initial or continued eligibility for Medicaid. This includes delayed processing of your application, actions to deny your request for medical services, or actions to reduce or terminate coverage after your eligibility has been determined.

To request an appeal, notify DMAS and/or your MCO in writing of the action you disagree with within 30 days of receipt of the agency's notice about the action. You may write a letter or complete an Appeal Request Form. Appeal Request Forms are available online at www.dmas.virginia.gov (under client services).

Please be specific about what action or decision you wish to appeal and include a copy of the notice about the action if you have it. Be sure to sign the letter or form. Appeal requests can be mailed to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Telephone: (804) 371-8488
Fax: (804) 371-8491

If you are appealing reduction or termination of coverage and your request is made before the effective date of the action, your coverage may continue pending the outcome of the appeal. You may, however, have to repay the Medicaid program for any services you receive during the continued coverage period if the agency's action is upheld.

After you file your appeal, you will be notified of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

The Hearing Officer's decision is the final administrative decision rendered by the Department of Medical Assistance Services. If you disagree with the Hearing Officer's decision you may appeal it to your local circuit court.

PRIVACY INFORMATION

When you receive health care services from an agency like DMAS, that agency may get medical (health) information about you. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your health information is protected. Health information includes any information that relates to: (1) your past, present or future physical or mental health or condition, (2) providing health care to you, or (3) the past, present or future payment of your health care.

Your Information. Your Rights. Our Responsibilities.

This section describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We *never* share or sell your information for marketing purposes.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your Company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request or on our website.

DEFINITIONS

Activities of Daily Living	Personal care tasks, (e.g. bathing, dressing, toileting, transferring, and eating/feeding). An individual's degree of dependence in performing these activities is part of determining the appropriate level of care and service needs.
Asset Transfer	Medicaid applicants and recipients must be fully compensated for any transfers of money, property or other assets.
Authorized Representative	Person who is authorized in writing to conduct the personal or financial affairs for an individual.
Caseworker	Eligibility Worker at the local department of social services who processes the application to determine Medicaid eligibility and maintains the ongoing case. This is the person to contact regarding changes, such as address or income, or problems, such as not receiving the Medicaid card.
Certified Application Assistor	Volunteer trained by the government and authorized by you to assist with your application.
Coinsurance	The portion of Medicare, Medicaid, or other insurance, allowed charges for which the patient is responsible.
Co-Payment	The portion of Medicaid-allowed charges which a member is required to pay directly to the provider for certain services or procedures rendered.
DMAS	Department of Medical Assistance Services, the agency that administers the Medicaid program in Virginia.
DSS	Department of Social Services, the agency responsible for determining eligibility for medical assistance and the provision of related social services. This includes the local departments of social services.
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a program of preventive health care and well child examinations with tests and immunizations for children and teens from birth up to age 21. Medically necessary services needed to correct or improve defects and physical or mental illnesses (discovered during a screening examination) may be covered as a part of the EPSDT program even if they are not covered under the State's Medicaid benefit plan.

FAMIS	Family Access to Medical Insurance Security is Virginia’s Children’s Health Insurance Program that helps pay for medical care for children under age 19 and pregnant women, FAMIS MOMS. FAMIS has higher income limits than Medicaid.
FAMIS Plus	An assistance program that helps pay for medical care for children under age 19 whose family income is within 133% of the Federal Poverty Limit for the family size.
Fraud	A deliberate withholding or hiding of information or giving false information to obtain or attempt to obtain Medicaid benefits.
Generic Drugs	Copies of drugs that are the same as a brand-name drug in dosage, safety, strength, quality, performance, and intended use. The Food and Drug Administration requires generic drugs to have the same quality, strength, purity, and stability as brand name drugs. Manufacturers of generic drugs don’t have the same investment costs as a developer of new drugs; therefore generic drugs are less expensive.
Health Insurance Marketplace (HIM)	Online marketplace of private insurance plans. Individuals can shop for health insurance, compare private plans, and determine whether they qualify for a subsidy to help pay for insurance.
Managed Care	Delivery of health care services emphasizing the relationship between a primary care provider (PCP) and the Medicaid member (referred to as a “medical home”). The goal of managed care is to have a central point through which all medical care is coordinated. Managed care has proven to enhance access to care, promote patient compliance and responsibility when seeking medical care and services, provide for continuity of care, encourage preventive care, and produce better medical outcomes. Most Virginia Medicaid members are required to receive their medical care through managed care programs.
MCO	Managed Care Organization is a health plan contracted to provide medical services and coordinate health care services through a network of providers.
Medicaid	An assistance program that helps pay for medical care for certain individuals and families with low incomes and resources.
Medically Necessary	Reasonable and necessary services for the diagnosis or treatment of an illness or injury or to improve physical functioning.

Patient Pay	Individuals with income may have to contribute to the cost of their long-term care services.
Primary Care Provider (PCP)	The doctor or clinic that provides most personal health care needs, gives referrals to other health care providers when needed, and monitors Medicaid member health. A PCP may be an internist, a pediatrician (children's doctor), OB/GYN (women's doctor), or certain clinics and health departments.
Uniform Assessment Instrument (UAI)	Pre-Admission Screening form completed by team that evaluates applicants' ability to complete activities of daily living.
Resources (Assets)	Resources include money on hand, in the bank, and in a safe deposit box; stocks, bonds, certificates of deposit, trusts, pre-paid burial plans; cars, boats, life insurance policies, and real property.
SSI	Supplemental Security Income is a federal program administered by the Social Security Administration that pays monthly benefits to individuals who are disabled, blind or age 65 or older with limited income and resources. Children and adults who are blind or disabled can receive SSI benefits.

ADDRESSES, PHONE NUMBERS, and WEBSITES

Local departments of social services in your city or county

Check the government (blue) pages of the local telephone book for the proper contact number for the following information:

- Questions about applying for Medicaid or your eligibility for the program
- Report a change in residence, income, or other significant event
- Questions about pre-admission screening for long-term care services
- Request Fact Sheets about Medicaid eligibility

Virginia Department of Social Services

For questions or concerns regarding the actions of staff employed by your local department of social services, write the Virginia Department of Social Services, Bureau of Customer Service, 801 E. Main Street, Richmond, Virginia 23219. You can also call the customer service hotline at 1-800-552-3431 or email your concern to www.citizen.services@dss.virginia.gov

Department of Medical Assistance Services www.dmas.virginia.gov

- For Medicaid **appeal** information, call (804) 371-8488
- Client Medical Management (**CMM**) 1-888-323-0589
- Dental Services, **Smiles for Children**, 1-888-912-3456
- For information about **FAMIS and Medicaid**, call Cover Virginia 1-855-242-8282
- To report Medicaid **fraud or abuse**, call the DMAS Recipient Audit Unit at (804) 786-0156 or your local department of social services or 804-786-1066 and toll free 1-866-486-1971
- Health Insurance Premium Payment Program (**HIPP**) call toll free, 1-800-432-5924
- For information about **Managed Care** enrollment, comparison charts and MCO contact information call 1-800-643-2273 or visit <http://www.virginiamanagedcare.com>
- For problems with bills or services from providers call the **Recipient Helpline** at 804-786-6145, or write the Recipient Services Unit at the address on the cover of this handbook
- **Transportation** To schedule transportation for a Medicaid covered service appointment (if you are not enrolled in an MCO), call **Logisticare** toll free, 1-866-386-8331
- Medical service providers submit requests for treatment prior authorization to **KePRO**, Virginia's health utilization management company. Services that do not require preauthorization include pharmacy, dental and transportation.
- For Behavioral Health information call Magellan at 1-800-424-4046 or visit www.magellanofvirginia.com

Cover Virginia www.coverva.org

Centers for Medicare and Medicaid Services www.cms.hhs.gov

Social Security Administration www.ssa.gov

Virginia Department of Social Services www.dss.virginia.gov

CommonHelp <https://commonhelp.virginia.gov/access/>

OTHER RESOURCES

Eligibility for **Medical Assistance, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Heating and Cooling Assistance and Childcare Assistance** are determined by your local department of social services www.dss.virginia.gov.

CommonHelp is a web-based service that will let you:

- Screen for eligibility for social services benefits and services
- Apply for benefits and services (including renewals)
- Check the status of benefits
- Report changes

CoverVa.org – Virginians can get information regarding Medicaid, the Federal Health Insurance Marketplace and other community health care options from the Cover Virginia website. Virginians without access to a computer can apply for Medicaid or FAMIS by dialing the Cover Virginia Call Center at 1-855-242-8282.

www.healthcare.gov Individuals can access the Federal Health Insurance Marketplace online at this website or by calling 1-800-318-2596 to purchase private health insurance. They can determine if they are eligible for federal tax credits subsidies to help pay for health insurance.

Early Intervention services are available throughout Virginia to help infants and toddlers (under age three) who have developmental delays or disabilities and their families. Contact Infant & Toddler Connections of Virginia 804-786-3710 or www.infantva.org.

Head Start is a federally funded pre-school program that serves low-income children and their families. Contact your local school division for more information or www.headstartva.org.

The **Virginia Healthy Start Initiative (VHSI)** is designed to reduce infant mortality in these areas: Norfolk, Petersburg, Portsmouth and Westmoreland County. Contact the Healthy Start Program Coordinator at the Virginia Department of Health at 804-864-7764 or www.vdh.virginia.gov/LHD/threeriv/HealthyStart.htm.

Schools are key links to improve child health. Schools help identify children's health problems and inform families about Medicaid Assistance and the EPSDT program. See the Virginia Department of Education website for more information:
www.doe.virginia.gov/students_parents/.

Teenagers are at high risk for poor birth outcomes, both medically and socially. The **Resource Mothers Program** trains and supervises laywomen to serve as a social support for pregnant teenagers and teenage parents of infants. The program helps low-income pregnant teenagers get prenatal care and other community services, follow good health care practices and continue in school. It also encourages the involvement of the infant's father and teens' parents to create a stable, nurturing home. For further information, contact the Division of Women's and Infants' Health, Virginia Department of Health at (804) 864-7768 or go to www.vdh.state.va.us.

Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a supplemental food and nutrition education program that provides vouchers for the purchase of specific nutritious foods. It provides nutrition counseling to pregnant, postpartum, or breastfeeding women, infants, and children under age five with nutritional and financial needs. Your child's doctor or EPSDT screening providers must refer eligible infants and children to the local health department for additional information and a WIC eligibility determination. Contact them by calling 1-888-942-3663 or online at www.wicva.com/